

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10

00819

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH: Somerset
 County.....
 City or town..... Crisfield
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....
 Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State..... Md. County..... Somerset
 City or town..... Crisfield
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME
 Stella May Ames

4. Sex..... 5. Color or race..... 6.(a) Single, married, widowed, or divorced
 Female Negro Married
 John Williams Ames

8. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... 6.(c) If alive, give age..... years
 March 3 1902 39

8. AGE: Years Months Days If less than one day
 42 8 ? hrs. min.

9. Birthplace..... (Town, county, and state)
 Crisfield Somerset Maryland

10. Usual occupation..... Crab Picker
 11. Industry or business..... Sea Food

FATHER: 12. Name..... Alex Pickney
 13. Birthplace..... Unknown

MOTHER: 14. Maiden name..... Sarah Milbourne
 15. Birthplace..... Unknown
 John Williams Ames

16. Informant..... 4th St Crisfield Md
 Address

17. Burial..... Date thereof..... Jan 31 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Asbury cemetery
 Location..... Crisfield Md

18. Funeral director..... John A. Bradshaw
 Address

19. Date rec'd by registrar..... 1/31/45 19..... 6. E. Collins, M.D.
 (Date rec'd by registrar) Registrar

3. (b) Social Security Number
 217-05-80 75

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan. 27 1945 at 3:17 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan. 25 1945 to Jan. 27 1945, and that I last saw her alive on Jan. 26 1945.

Immediate cause of death..... Labor pneumonia + weak heart

Due to.....

Due to.....

Other conditions..... Arthritis for several years -
 (Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

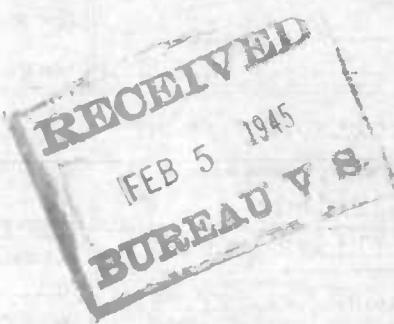
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Motus of injury..... Injured at work?

23. SIGNATURE..... W. J. Bachley, M.D.

M. D. or other.....
 Address..... 309 W. 3rd Ave. Date signed..... 1/31/45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 490

00820

CERTIFICATE OF DEATH

Reg. Dist. No. 270

1. PLACE OF DEATH: Somerset
 County.....
 City or town..... Crisfield
 (If outside city or town limits, write RURAL and give nearest town) 28 yrs
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:.....
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State..... Md. County..... Somerset
 City or town..... Crisfield
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
 Susan Emily Burke

3. (b) Social Security Number
 215-05-8875

4. Sex..... Female Color or race..... White Marital status..... Married

Name of husband or wife..... Charles F Burke

6. (c) Name of husband or wife.....
 7. Birth date of deceased (mo., day, yr.) Oct 1 1891
 6. (c) If alive, give age..... 68 years

8. AGE: Years..... 53 Months..... 3 Days..... 9 If less than one day
 hrs..... min.....
 Tangier Autcomac Virginia

9. Birthplace..... (Town, county, and state)

10. Usual occupation..... Sewing Operator

11. Industry or business..... Garment Factory

12. Name..... Thomas Pruitt
 13. Birthplace..... Tangier Va

14. Maiden name..... Eliza J Parks

15. Birthplace..... Tangier Va

16. Informant..... Chas F Burke
 Address..... Crisfield Md

Burial..... Jan 12 1945
 17. (Burial, cremation, or removal, which?) Date thereof..... (month) (day) (year)
 Cemetery or crematory..... Crisfield cemetery

Location..... Crisfield Md

18. Funeral director..... John A Bradshaw
 Address..... Crisfield Md

19. Date rec'd by registrar..... Jan. 11, 1945
 L. E. Collins M. D.
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan 11, 1945, at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 1, 1944, to Jan. 10, 1945, and that I last saw her alive on Jan. 10, 1945.

Immediate cause of death..... Acute heart

Due to..... Cardiac and pulmonary - Acute heart

But to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Autopsy results..... No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... George E. Gallum, M. D.

M. D. or other

Address..... Munro St. Md. Date signed Jan. 11, 1945



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

00821

CERTIFICATE OF DEATH

Reg. Dist. No. 260

1. PLACE OF DEATH:

County

Somerset County
Westover, Maryland

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Cleota Cleothel Collins

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F

Col

Boy

6. (b) Name of husband or wife

7. Birth date of
deceased (mo., day, yr.)

December 7 1944

6. (c) If alive, give age.....years

8. AGE:

Years

Months

Days

If less than one day

1

11

hrs.

min.

9. Birthplace

Westover Somerset Co.

(Town, county, and state)

10. Usual occupation

Body

11. Industry or business

MOTHER FATHER

12. Name

Albert Collins

13. Birthplace

Westover, Md

MOTHER

14. Maiden name

Ellen Collins

15. Birthplace

Westover

16. Informant

Mrs. Ellen Collins

Address

Westover, Md

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

1/19-45

(month day year)

Cemetery or crematory

Westover

Location

18. Funeral director

F. C. Johnson (Albert Collins)

Address

Westover

19. (Date rec'd by registrar)

1/19

1945

Date signed

1/19

1945

Registrar

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

Somerset

City or town

Westover

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

January 18 1945 at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.

19.

and that I last saw h.....alive on

19.

Immediate cause of death

Severe pneumonia

DURATION

I did not see body
but from history and
information from Public
Health nurse who body
accidently had a cold
Other conditions the developed pneumonia

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. Johnson M. D.

deputy state health officer

M. D. or other

Address

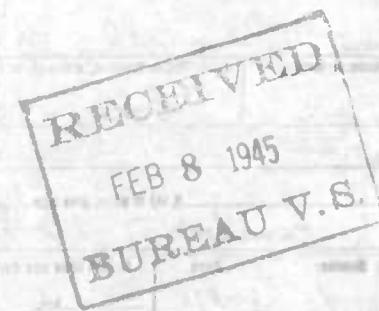
Date signed

1/19-45

WIRGINIA STATE DEPARTMENT OF HEALTH

101 W. CASH ST. - MELVILLE

CERTIFICATE OF DEATH



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 7-12

00822

CERTIFICATE OF DEATH

Reg. Diat. No... 2605

1. PLACE OF DEATH: Somerset
County..... Crisfield
City or town..... (If outside city or town limits, write RURAL and give nearest town) 52 yrs
How long in above place of death?.....
Hospital, institution, or street address where death occurred:.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... 1d County..... Somerset
City or town..... Crisfield (If outside city or town limits, write RURAL and give nearest town)
Street No..... (If rural, give LOCATION)

3. (a) FULL NAME
Garfield Collins

3. (b) Social Security Number

4. Sex Male 5. Color or race Col. 6.(a) Single, married, widowed, or divorced Widowed

Corine Collins

6.(b) Name of husband or wife.....
7. Birth date of deceased (mo., day, yr.) April 1 1892 6.(c) If alive, give age..... years

8. AGE: Years 52 Months 9 Days 1 If less than one day hrs. min.

Crisfield Somerset Maryland

9. Birthplace..... (Town, county, and state) Laborer

10. Usual occupation.....

11. Industry or business

FATHER 12. Name..... Garfield Collins Sr
13. Birthplace..... Crisfield MdMOTHER 14. Maiden name..... Sarah Carr
15. Birthplace..... Fairmount Md16. Informant..... Effie Williams
Address..... Crisfield Md17. Burial Date thereof..... Jan 25 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... Asbury cemetery
Location..... Crisfield Md18. Funeral director..... John A Bradshaw
Address..... Crisfield Md19. Date rec'd by registrar..... 1/24/45 19..... G E Collins M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 22 1945 21. 8:30 A.M.

21. CERTIFY that death occurred on the date above stated: that I attended deceased from found dead in bed and that I last saw deceased in bed.

Immediate cause of death..... front door

Due to..... Coronary

Due to..... occlusion

William H. Coulbourn, M.D.

Other conditions..... DEPUTY MEDICAL EXAMINER

(Include pregnancy within 8 months of death)

Major findings or operations..... Date of op.

Autopsy results..... no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... no Date of.....

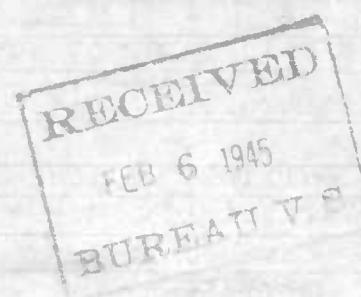
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... M. D. or other

Address..... Crisfield Md Date signed..... Jan 24, 1945



M

MARGIN RESERVED FOR BINDING

1

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-24

00824

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH: Somerset
 County
 City or townGrisfield R.F.D. 2
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?70 yrs
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Charles B. Coulbourn

4. Sex Male 5. Color or race colored 6. (a) Single, married, widowed, or divorced widower

6. (b) Name of husband or wife Eliza Coulbourn7. Birth date of deceased (mo., day, yr.) May 15-1874 6. (c) If alive, give age years8. AGE: 70 Years 8 Months 10 Days If less than one day hrs. min.9. Birthplace Hopewell Somerset Co Md
 (Town, county, and state)10. Usual occupation laborer

11. Industry or business

12. Name Samuel G Coulbourn13. Birthplace Hopewell Somerset Co Md14. Maiden name Charlotte Miles15. Birthplace Hopewell Somerset Co Md16. Informant Mary G CoulbournAddress Grisfield R.F.D. 2 Md17. burial (Burial, cremation, or removal. Which?) Date thereof Jan 28 1885

(month) (day) (year)

Cemetery or crematory Home cemeteryLocation Hopewell Md18. Funeral director Chas H WardAddress Marietta Md.19. 1/22/45 19. C. E. Geller Registrar

(Date rec'd by registrar) (Date signed) (Signature of Registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Md County Somerset
 City or town Grisfield R.F.D. 2
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 25 19.45 at 9:50 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 25 19.45 to Jan. 25 19.46 and that I last saw him alive on Jan. 25 19.46Immediate cause of death Cerebral hemorrhage DURATION 24 hrs.Due to Hard arteries for 2 yrs.Due to Other conditions Paralysis right side DURATION 24 hrs.

(Include pregnancy within 8 months of death)

Major findings of operations Date of op.

Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

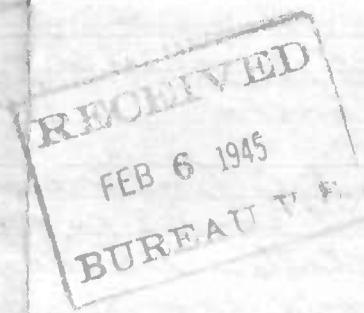
Accident, suicide, or homicide Date of (City or town) (County) (State)

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. J. Mackley M.D. M. D. or other (Signature of physician)Address 309 W. Md. Ave. Date signed 1/22/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

BPD

00825

261

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County *Maryland*City or town *Maryland* *Rural*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *one day*

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Emma Jane Doris

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*Female**White**Married*6. (b) Name of husband or wife *Robert M. Doris*7. Birth date of deceased (mo., day, yr.) *Nov 19* *1944*6. (c) If alive, give age *years*8. AGE: Years *63* Months Days If less than one day hrs. min. 9. Birthplace *va. Norfolk*

(Town, county, and state)

10. Usual occupation *housewife*

11. Industry or business

12. Name *Daniel Burchess*13. Birthplace *va.*14. Maiden name *Mary B.*15. Birthplace 16. Informant *Police in town*Address *Maryland St. 200*17. Burial *Burial* Date thereof *Jan 15 1945*

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Liberia*Location *Hanover Station Md*18. Funeral director *George W. Johnson*Address *Hanover Station*19. *1944* *1945* *Aurilia P. Johnson*

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland*County *Maryland*City or town *Maryland* *Rural*

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

218-70-3341

MEDICAL CERTIFICATION

20. DATE OF DEATH *January 22* *1945* *at 12 45 p.m.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Nov 1**1944* *to Jan 22* *1945*and that I last saw her *alive* on *Jan 21* *1945*Immediate cause of death *stroke**and due to heart*

DURATION

Due to *closed heart right side**loss of consciousness*Due to Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations Date of op. Autopsy results

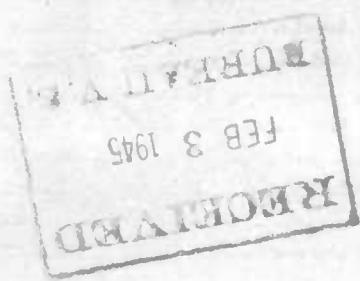
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work 23. SIGNATURE *Guy C. Crumpton M.D.*

M. D. or other

Address *Maryland St. 200* Date signed *Jan 23 1945*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3-21

00826

CERTIFICATE OF DEATH

Reg. Dist. No.

260

1. PLACE OF DEATH:

County SomersetCity or town Princess Anne

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 85 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Lussie De Shields

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Col

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Lake Franklin De Shields7. Birth date of deceased (mo., day, yr.) March 5 18606. (c) If alive, give age — years8. AGE: Years 84 Months 10 Days 16 If less than one day hrs. min.9. Birthplace Princess Anne, Somerset Co. Md.
(Town, county, and state)10. Usual occupation Labor11. Industry or business Farm12. Name Robert Johnson13. Birthplace Somerset Co., Md.14. Maiden name Margaret Johnson15. Birthplace Somerset Co. Md.16. Informant Thomas JohnsonAddress Princess Anne Md. Bldg. 217. Burial Burial Date thereof 1/24/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory College HillLocation Princess Anne Md.18. Funeral director ArthurAddress Marion Johnson19. Date rec'd by registrar Jan 22 1945

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Princess Anne Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21 1945

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Jan 16 '45 to Jan 21 1945and that I last saw her alive on Jan 20 1945

Immediate cause of death

Cerebral Haemorrhage

Due to

Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

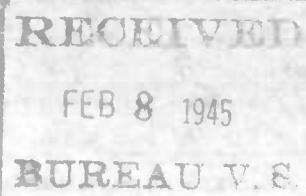
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Eduard C. M. Johnson
M. D. or otherAddress Princess Anne Md. Date signed 1-21-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 160

00827

CERTIFICATE OF DEATH

Reg. Dist. No.

268

1. PLACE OF DEATH:

County Somerset
City or town Wool Island, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

J. Raynor Graham

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MW

married

6. (b) Name of husband or wife Theresa Graham7. Birth date of deceased (mo., day, yr.) Nov. 19, 19058. (c) If alive, give age 33 years8. AGE: Years 39 Months 1 Days 25 If less than one dayhrs. min. 9. Birthplace Wool Island, Md.
(Town, county, and state)10. Usual occupation Oyster Business

11. Industry or business

12. Name James Graham13. Birthplace Wool Island, Md.14. Maiden name Katier Webster15. Birthplace Wool Island, Md.16. Informant Jane GrahamAddress Wool Island, Md.17. Burial Burial Date thereof Jan. 15, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Wool Island, Md.Location Wool Island, Md.18. Funeral director Wade WashellAddress Princess Anne, Md.19. Date rec'd by registrar Jan. 14 1945 Rosa Webster
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County SomersetCity or town Wool Island, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12 1945 at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 19 1945

and immediate cause of death.....

Internal hemorrhage
from bullet woundDue to in abdomen

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

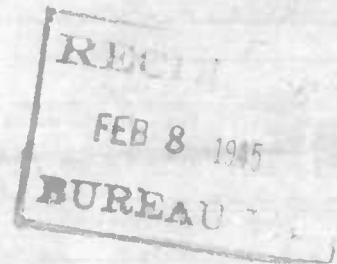
Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Homicide Date of 1/12/45Where did injury occur? Wool Island County Somerset State Md.Injured at home, farm, industry, public place (where?) IndustryMeans of injury Bullet wound Injured at work? Replay medical equipment23. SIGNATURE Fay M. Lumbard M. D. or other Address Princess Anne, Md. Date signed 1/13/45

RECEIVED BY THE DEPT. OF STATE - WASH. D. C.
FEB 8 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4

00828

FILM NO. G 92 MAR 10 1945

CERTIFICATE OF DEATH

Reg. Dist. No. 268

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or Institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME

Kellie Daniel Horner

3.(b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female

White

Married

6.(b) Name of husband

Walton Harvey Jr.

8.(c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

27th April

88 (If alive, give age..... years)

8. AGE:

Years
30

Months
-3-

Days
-

If less than one day
hrs. min.

9. Birthplace

Wenona, S. C. Md.

(Town, county, and state)

10. Usual occupation

Housewife

Home work

11. Industry or business

MOTHER

FATHER

12. Name

Arthur Daniel

13. Birthplace

Wenona, Md.

14. Maiden name

Vera Webster

15. Birthplace

Chancey, Md.

16. Informant

Burial

Elizabeth Webster

Address

Wenona, Md.

17. Cemetery or crematory

St. Pauls M. E.

Location

Wenona, Md.

18. Funeral director

Address

Deals Island

19. Date rec'd by registrar

Jan. 6th 1945

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 3- 1945 19 at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 25 1944 to Jan 1 1945

and that I last saw her alive on Jan 1 1945

Immediate cause of death Carrion

or Repture

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

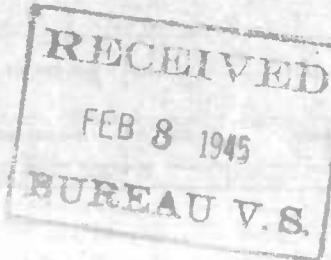
Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... Frank Matus M.D.

M. D. or other

Address..... Princess Anne Date signed 1/8/45



RECEIVED

FEB 8 1945

BUREAU F.B.I.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

00830

CERTIFICATE OF DEATH

Reg. Dist. No.

270

1. PLACE OF DEATH:

County

Somerset

City or town

Crisfield

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

4 DAYS

Hospital, institution, or street address where death occurred:

McCrady's Memorial Hospital

How long in hospital or institution?

4 DAYS

3. (a) FULL NAME

Ola COTTINGHAM JONES

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

FEMALE

Colored

MARRIED

THOMAS JONES, JR.

6. (b) Name of husband or wife

5. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

JUNE 29, 1907

8. AGE:

Years
37Months
6Days
29If less than one day
hrs. min.

9. Birthplace

MARION STATION (SOMERSET) MD.

(Town, county, and state)

10. Usual occupation

DOMESTIC

11. Industry or business

CHARLES M. COTTINGHAM

12. Name

MOTHER FATHER

MARION STATION

13. Birthplace

ADDIE O. OUTTEN

14. Maiden name

LIBERIA (MARION) MD.

15. Birthplace

ELLEN TURPIN

16. Informant

R. I. MARION, MD.

Address

BURIAL

Date thereof
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Family

Location

Wesley (Marion) MD.

18. Funeral director

S. W. Tighman

Address

MARION, MD.

19. (Date reg'd by registrar)

1945

1945

Signature of Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

MARYLAND County

City or town

MARION STATION

(If outside city or town limits, write RURAL and give nearest town)

Street No.

R. I.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 1945 at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 25 1945 to January 27 1945

and that I last saw her alive on January 27 1945

Immediate cause of death

Acute rheumatic heart

stroke

Due to

Rheumatic

DURATION

Due to

Pulmonary

Cerebrovascular

Weeks

Other conditions

(Include pregnancy within 3 months of death)

Major findings at operation

None observed

Offendeces

Double bypass

sclerotic

Date of op Jan 26-45

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

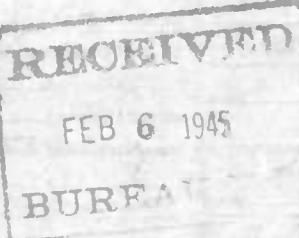
23. SIGNATURE

Guy C. Ellman, M.D.

M. D. or other

Address

Date signed Jan 30-45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 330

00831

CERTIFICATE OF DEATH

Reg. Dist. No.

265

1. PLACE OF DEATH: Somerset
 County Crisfield
 City or town (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 months
 Hospital, Institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Md County Somerset
 City or town Crisfield (If outside city or town limits, write RURAL and give nearest town)
 Street No. Mariners Rd. (If rural, give LOCATION)
 2.(a) If veteran, name war none

3. (a) FULL NAME
 Eddline Keyser

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced
 male white widower

6.(b) Name of husband or wife Ida Mae

7. Birth date of deceased (mo., day, yr.) 6.(c) If alive, give age years
 February 1873

8. AGE: Years Months Days If less than one day
 71 11 hrs. min.

9. Birthplace Virginia
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business self

MOTHER FATHER
 12. Name unknown
 Va.

13. Birthplace unknown
 Va.

MOTHER FATHER
 14. Maiden name unknown
 Va.

15. Birthplace Murphy L. Keyser
 Mariners Rd. Crisfield, Md

Address Burial 1/28/45
 17. (Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)

Cemetery or crematory Totutey
 Location Haynesville, Va.

18. Funeral director Howard H. Hubbard
 Address 508 Main St., Crisfield, Md

19. 19 68 Calmar M.D.
 (Date rec'd by registrar) Registrar

3. (b) Social Security Number none

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26 1945, at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 26 1945, to Jan. 26 1945, and that I last saw him alive on Jan. 26 1945.

Immediate cause of death Cancer of the cervical gland
 & metastasis to the lungs

Due to (List causes of death)

Due to (List causes of death)

Other conditions (Include pregnancy within 3 months of death)

Major findings or operations Date of op.

Autopsy results Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

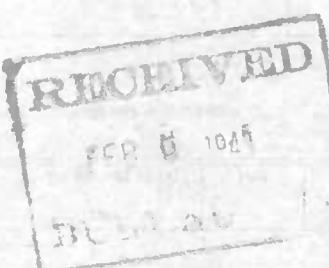
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. M. Peyton M.D.

M. D. or other Date signed Jan. 27, 1945

Address Crisfield, Md



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 810

Dr. Payton
00832

CERTIFICATE OF DEATH

Reg. Dist. No. 270

1. PLACE OF DEATH: Somerset
County Crisfield
City or town (If outside city or town limits, write RURAL and give nearest town) 3 yrs
How long in above place of death?
Hospital, Institution, or street address where death occurred: McCready Memorial Hospital
How long in hospital or institution? 1 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. Somerset
County Crisfield
City or town (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war.

3. (a) FULL NAME

Franklin Thomas Laird

3. (b) Social Security Number

4. Sex	5. Color or race	B.(a) Single, married, widowed, or divorced
Male	White	Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) June 7 1859, 1939
6. (c) If alive, give age years8. AGE: Years Months Days If less than one day
5 7 5 hrs. min.9. Birthplace Princess Anne, Somerset, Maryland
(Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name Clayton Laird
13. Birthplace Oriole, Md14. Maiden name Daisy Bell Abbott
15. Birthplace Weona, Md16. Informant Clayton Laird
Crisfield, Md
Address17. Burial Date thereof Jan 15 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)
Oriole cemeteryCemetery or crematory
Location Oriole, Md18. Funeral director John A Bradshaw
Crisfield, Md
Address

19. 1/5/45 (Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 1, 1945, at 6 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1, 1945, to Jan. 1, 1945, and that I last saw him alive on Jan. 1, 1945.

Immediate cause of death

Non-specific, not reported, because the diagnosis was in doubt.
Due to There was no autopsy. C.R.P.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results There was no autopsy.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. W. Payton M.D.

M. D. or other

Address Crisfield, Md Date signed Jan. 13, 1945

RECEIVED

FEB 6 1945

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

CERTIFICATE OF DEATH

00833

Reg. Dist. No. 265

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15

1. PLACE OF DEATH: Somerset
 County
 City or town
 (If outside city or town limits, write RURAL and give nearest town) Crisfield
 1 da
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 Md County
 Somerset
 State
 City or town
 (If outside city or town limits, write RURAL and give nearest town) Kingston
 Street No.
 (If rural, give LOCATION)

3. (a) FULL NAME
 Mary Elizabeth Jones Maddox

4. Sex Female 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Will Maddox

7. Birth date of deceased (mo., day, yr.) Sept 12 1898

6. (c) If alive, give age 58 years

8. AGE: Years 46 Months 4 Days 0 If less than one day hrs. min.

9. Birthplace Kingston Somerset Maryland
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Unknown

13. Birthplace

14. Maiden name Eliza King

15. Birthplace Kingston Md

16. Informant Will Maddox

Address Kingston Md

17. Burial Jan 14 1945
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Kingston cemetery

Location Kingston Md

18. Funeral director John A. Bradshaw

Address Crisfield Md

19. 1/12/45 1945 686 Calusa Rd

Registrar

3. (b) Social Security Number
 214-12-5684

MEDICAL CERTIFICATION

20. DATE OF DEATH January 12 1945 at M

21. CERTIFY that death occurred on the date above stated. That I attended deceased from

Was dead when seen 1945

At that I last saw her. Deceased - 1945

Immediate cause of death

Hemorrhage in

Obstruction of

Due to

Hemorrhage

Myocarditis

Due to

Hemorrhage

Other conditions

Maternal cause

(Include pregnancy within 1 month of death)

William H. Coulbourn, M. D.

Major findings or operations

DEPUTY MEDICAL EXAMINER

Date of op.

FOR SOMERSET COUNTY, MD.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

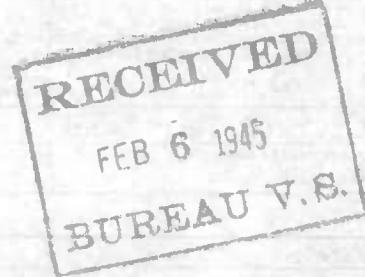
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Crisfield Md Date 1/12/45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00834

Reg. Dist. No. 270

1. PLACE OF DEATH: Somerset
 County..... Crisfield rural
 City or town..... (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 15 yrs
 Hospital, Institution, or street address where death occurred: McCready Memorial Hospital
 How long in hospital or institution? 4 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Md County..... Somerset
 City or town..... Crisfield RURAL
 Street No..... (If outside city or town limits, write RURAL and give nearest town)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Robert McR. Martin

3. (b) Social Security Number
None

4. Sex Male	5. Color or race White	6.(a) Single, married, widowed, or divorced Single
----------------	---------------------------	---

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.) Unknown8. AGE: Years Months Days If less than one day
About 65 hrs. min.9. Birthplace..... Unknown
(Town, county, and state)

10. Usual occupation..... Farm Laborer

11. Industry or business.....

12. Name..... Unknown
" "

13. Birthplace..... " "

14. Maiden name..... " "

15. Birthplace..... " "

16. Informant..... John Brittingham
Address Crisfield Md RURAL17. Burial..... Date thereof..... Jan 29-45
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory..... Private cemetery on farm
Location..... Crisfield Md18. Funeral director..... John A Bradshaw
Address Crisfield Md19. (Date rec'd by registrar) 1945
Signature Garcia B. Dawson
Address Crisfield Md

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan 27 1945 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Jan 27 1945, to Jan 27 1945
and that I last saw him alive on Jan 27 1945

Immediate cause of death..... Acute Disseminated Encephalitis

Due to..... Chronic Disseminated Encephalitis

Due to..... Chronic Encephalitis

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

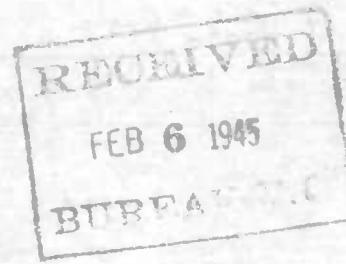
Injured at home, farm, Industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE George S. Coulson M.D.

M. D. or other

Address Crisfield Md Date signed Jan 28 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1068

00835

CERTIFICATE OF DEATH

Reg. Dist. No. 260

1. PLACE OF DEATH:

Somerset

County

Princess Anne

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Years

Hospital, Institution, or street address where death occurred.

How long in hospital or institution?

3. (a) FULL NAME

Virginia Francis Toniles

4. Sex

Fem

5. Color or race

Col

6.(a) Single, married, widowed, or divorced

Widowed

8. (b) Name of husband

Wm. H. Toniles

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Jan 9th 1864

8. AGE:

Years
80Months
11Days
27

If less than one day

hrs.

min.

9. Birthplace

Somerset County, Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own Home

MOTHER FATHER

12. Name

Henry T. Curtis

13. Birthplace

Somerset County, Md.

14. Maiden name

Susan Francis Hershey

15. Birthplace

Somerset County, Md.

16. Informant

Rev. B. T. Hershey

Address

Princess Anne, Md. B-36

17. Burial

Burial (Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory

Wesley Cemetery

Location

Marion Station, Md.

18. Funeral director

Wade Washell

Address

Princess Anne, Md.

19. Date rec'd by registrar

Jan 8th 1945

19. Date rec'd by registrar

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset

City or town Princess Anne

(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6th 1945 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 15th 1944 to Jan 6th 1945

and that I last saw her alive on Jan 5th 1945

Immediate cause of death

Chronic Bronchitis

DURATION

24 years

Due to

Due to

Other conditions Pulmonary Hemorrhage

1.6.45

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

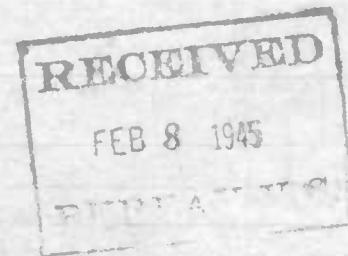
Injured at work?

23. SIGNATURE

Eleanor G. M. Johnson

M. D. or other

Address Princess Anne, Md. Date signed Jan 9, 1945



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-2)

00836

CERTIFICATE OF DEATH

Reg. Dist. No.

290

1. PLACE OF DEATH:

County: Somerset
City or town: Crisfield Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? XXXXX Life

Hospital, institution, or street address where death occurred:

McCredy Memorial Hospital
4 days

How long in hospital or institution?

3. (a) FULL NAME

Alice May Nelson

4. Sex: female | 5. Color or race: white | 6. (a) Single, married, widowed, or divorced: married

6. (b) Name of husband or wife: Gordon Lee Nelson

7. Birth date of deceased (mo., day, yr.): December 22, 1899 | 6. (c) If alive, give age: 46 years

8. AGE: 46 | Years | Months | Days | If less than one day: .hrs. .min.

9. Birthplace: Crisfield, Md.

(Town, county, and state)

10. Usual occupation: Operator

11. Industry or business: Rosenblooms Factory

12. Name: William Tyler

Crisfield, Md.

13. Birthplace: Crisfield, Md.

14. Maiden name: Georgia Ward

Crisfield, Md.

15. Birthplace: Crisfield, Md.

16. Informant: Gordon L. Nelson

Crisfield, Md.

Address:

17. Burial: Burial Date thereof: 1/14/45

(Burial, cremation, or removal. Which?)

Asbury Rd Cemetery

Cemetery or crematory:

Location: Crisfield, Md.

Howard H. Hubbard

18. Funeral director: 500 Main St., Crisfield, Md.

Address:

19. 1/13 1945

(Date reg'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
Id. | County: Somers et

State: Crisfield | City or town: (If outside city or town limits, write RURAL and give nearest town)

Street No.: (If rural, give LOCATION)

2. (a) If veteran, name war: none

3. (b) Social Security Number

216-07-1748

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 12, 1945 | 19 | at 2 AM | M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 15 | 1944 to Jan. 12 | 1945

and that I last saw h. w. alive on Jan. 12 | 1945

Immediate cause of death: Tumour

and Pneumonia neglect

Due to: Cancer of neglect

Due to: Cancer of neglect

Other conditions: Other

(Include pregnancy within 8 months of death)

Major findings of operations: Date of op.

Autopsy results: Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Alice B. Fawcett, M.D.

M. D. or other: M.D.

Address: 500 Main St., Crisfield, Md. Date signed: Jan. 13, 1945



M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Be*

00837

CERTIFICATE OF DEATH

Reg. Dist. No. *2100*

1. PLACE OF DEATH:

County *Somerset*
 City or town *Princess Anne, Md.*
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Charles William Stevenson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m colored married
 6. (b) Name of husband or wife *mary E Stevenson*

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age years

8. AGE: Years	Months	Days	If less than one day
<i>33</i>	<i>2</i>	<i>2</i>	<i>hrs. min.</i>

9. Birthplace *Somerset Co.*
 (Town, county, and state)10. Usual occupation *farmer labor*

11. Industry or business

12. Name *Lippe Stevenson*13. Birthplace *Princess Anne, Md.*14. Maiden name *maggie adams*15. Birthplace *Somerset Co.*16. Informant *James Alford*Address *Princess Anne, Md.*17. Burial Date thereof *1-14-45*
 (Burial, cremation, or removal. Which?) *(month) (day) (year)*Cemetery or crematory *Curtiss Chapel*Location *Somerset Co.*18. Funeral director *William James & Son*Address *Princess Anne, Md.*19. *Jan 13 1945* (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *md* County *Somerset*
 City or town *Princess Anne, Md. T.P.D.*
 (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *Jan 11*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on *19 10 19*

Immediate cause of death

acute Heart Disease

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury *Bicycle* Injured at work *Modern*23. SIGNATURE *Henry M. Mountford M.D.*

M. D. or other

Address *Princess Anne, Md.* Date signed *11/2/45*

RECEIVED

FEB 8 1945

BURHAT

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

17 00838

CERTIFICATE OF DEATH

Reg. Dist. No. 220

1. PLACE OF DEATH:

County

Somerset

City or town

Edgewater and St. Mary's Hospital

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

2 days

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2 days

3. (a) FULL NAME

John Wesley Stewart

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M

Colored

Married

7. (b) Name of husband or wife

Emma L. Stewart

not known

8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1900

8. AGE: Years Months Days If less than one day

44 - - hrs. min.

9. Birthplace

Princess Anne, Md. P.E.D.

(Town, county, and state)

10. Usual occupation

farmer

11. Industry or business

12. Name

William Stewart

13. Birthplace

Somerset

14. Maiden name

Elaine Stewart

15. Birthplace

Somerset

16. Informant

Emma L. Stewart

Address

Princess Anne, Md.

17. Burial

(Burial, cremation, or removal) Which?

Date thereof

(month) (day) (year)

Cemetery or columbarium

St. Mark

Location

Oakville, Md.

18. Funeral director

William James & Son

Address

Princess Anne, Md.

19. Jan 5 1945

C. E. Callin, M.D.

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County

Somerset

City or town

Manokin, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

World War No. 1

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

January 2, 1945, a.m. 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 15, 1944, to January 2, 1945,

and that I last saw him alive on January 2, 1945.

Immediate cause of death

Hemiplegia

DURATION

3 days

Due to

Hypertension

6 mos.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

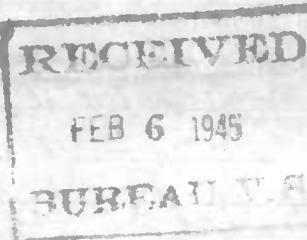
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

RECEIVED BY THE MASSACHUSETTS STATE ATTORNEY

MASSACHUSETTS ATTORNEY





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 774

00839

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH:		Somerset	
County.....		Crisfield	
City or town.....		(If outside city or town limits, write RURAL and give nearest town) 50-9-7	
How long in above place of death?.....			
Hospital, institution, or street address where death occurred:.....			
How long in hospital or institution?.....			
3. (a) FULL NAME			
Harold Smith Ward			
4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced	
Male	White	Married	
6. (b) Name of husband or wife.....		Minnie Tull Ward	
7. Birth date of deceased (mo., day, yr.)		8. (c) If alive, give age..... 45 years	
April 18 1894			
8. AGE:	Years	Months	Days
50	9	7	11 less than one day
			hrs. mts.
9. Birthplace..... Crisfield Somerset Maryland			
(Town, county, and state) Carpenter			
10. Usual occupation..... Building Houses			
11. Industry or business..... William H Ward			
12. Name..... William H Ward			
13. Birthplace..... Crisfield Md			
14. Maiden name..... Julia Daugherty			
15. Birthplace..... Crisfield Md			
16. Informant..... Mrs Minnie Ward			
Address..... Crisfield Md			
17. Burial.....		Date thereof..... Jan 28 1945	
(Burial, cremation, or removal. Which?)		(month) (day) (year)	
Cemetery or crematory.....		Crisfield cemetery	
Location.....		Crisfield Md	
18. Funeral director.....		John A Bradshaw	
Address.....		Crisfield Md	
19. (Date rec'd by registrar).....		1/26/45 19..... L E Collins, M.D.	
		Registrar	

2. USUAL RESIDENCE (HOME) OF DECEASED:	
(For newborn infants give residence of mother)	
State.....	Md
County.....	Somerset
City or town.....	Crisfield
(If outside city or town limits, write RURAL and give nearest town)	
Street No.....	
(If rural, give LOCATION)	
2. (a) If veteran, name war.....	

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 25 1945 11:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death.....

Alcoholism
Delirium

Due to.....

William H. Coulbourne, M.D.

Other conditions..... DEPUTY MEDICAL EXAMINER

FOR SOMERSET COUNTY, MD.
(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

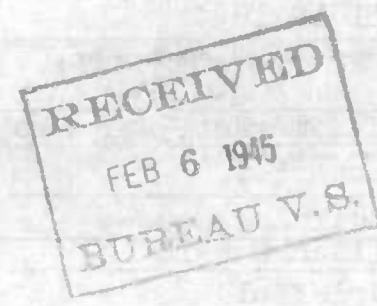
Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

M.D. or other.....

Address..... Crisfield Md..... Date signed..... 1/26/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85)

00823

CERTIFICATE OF DEATH

Reg. Dist. No. 360

Item 3:G202 9-4-56 L

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

B. (b) Name of husband or wife

7. Birth date of deceased (mo., day, year)

8. AGE: Year Months Days If less than one day

9. Birthplace (Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial (Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

WATERS

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 13, 1945 at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I saw the deceased alive

Immediate cause of death

Due to Epilepsy

Duration

Due to

Other conditions Possible Head Injury

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M.D. or other

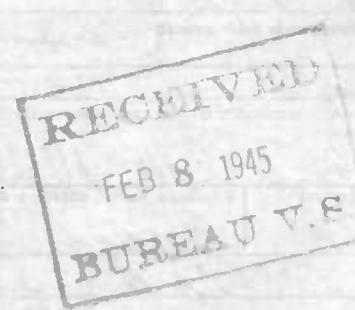
Address

Date signed

Signature

MEMORANDUM FOR THE DIRECTOR OF THE
FEDERAL BUREAU OF INVESTIGATION

MEMORANDUM FOR THE DIRECTOR OF THE
FEDERAL BUREAU OF INVESTIGATION



M

MARGIN RESERVED FOR BINDING

1

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 15

00840

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH:

County

Somerset

City or town

Baltimore Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

10 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Viola Watson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

J'me colord married

6. (b) Name of husband or wife..... Avan Watson

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age..... 29 years

Feb 2-1922

8. AGE: Years Months Days If less than one day

22 11 15 hrs. min.

9. Birthplace..... Gaithersburg, Md.

(Town, county, and state)

10. Usual occupation..... House worker

11. Industry or business

12. Name..... Alfred Tolson

13. Birthplace..... Gaithersburg, Md.

14. Maiden name..... Josephine Meltzer

15. Birthplace..... Gaithersburg, Md.

16. Informant..... Alfred Tolson

Address..... 189 North Fourth St Baltimore Md

17. Burial..... Date thereof..... (month) (day) (year)

(Burial, cremation, or removal. Which?) Cemetery or crematory..... Jan 21, 1945

Location..... Baltimore Md

18. Funeral director..... Ethel H. Ward

Address..... Marion Md

19. (Date rec'd by registrar)..... 1/19/45

(Date rec'd by registrar)..... 1/19/45

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md

County..... Somerset

City or town..... Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 129 N. Fourth St.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan 21, 1945 at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 25, 1944, to Jan 21, 1945,

and that I last saw her alive on Jan 20, 1945.

Immediate cause of death.....

Inflammation of heart and lungs

DURATION

2

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE..... S. M. Peyton, M.D.

M. D. or other

Address..... Baltimore Md Date signed..... Jan 21, 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

00841

CERTIFICATE OF DEATH

Reg. Dist. No. 268

1. PLACE OF DEATH: Somersb
 County Wicomico
 City or town Wicomico (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Retired
 Hospital, Institution, or street address where death occurred: Wicomico
 How long in hospital or institution?

3. (a) FULL NAME

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Virginia White

7. Birth date of deceased (mo., day, yr.) 1874 6. (c) If alive, give age years

8. AGE: Years 78 Months — Days — If less than one day hrs. — min.

9. Birthplace Wicomico Md (Town, county, and state)

10. Usual occupation Retired Waterman

11. Industry or business Fisher

12. Name John S. White

13. Birthplace Deals Island

14. Maiden name Maria A. Evans

15. Birthplace Deals Island

16. Informant Mrs Gladys Campbell

Address Wicomico

17. Burial Burial Date thereof Feb 1, 1945 (month day year)

(Burial, cremation, or removal. Which?) Deals Island Md

Cemetery or crematory Deals Island Md

Location Deals Island Md

18. Funeral director W. H. Webster

Address Deals Island Md

19. Date rec'd by registrar Feb 1, 1945 Registrar Rosa Welata
 (Date rec'd by registrar) 1945 (Date signed) 2/3/45

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Maryland County Somerset
 City or town Wicomico (If outside city or town limits, write RURAL and give nearest town)
 Street No. — (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30th 18 45 at 9 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 19 to 19

Immediate cause of death Myocarditis

DURATION

Death

Due to Arteriosclerosis

Due to —

Other conditions —

(Include pregnancy within 8 months of death)

Major findings of operations —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) — (County) — (State) —

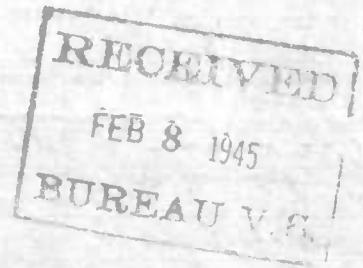
Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE J. Smith

M. D. or other

Address Baltimore Ave Date signed 2/3/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

102
00843

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH:

County Somerset
City or town Crisfield

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Katie S.B. Wilson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female

white

widow

6. (b) Name of husband or wife

James

7. Birth date of deceased (mo., day, yr.)

June 20, 1880

6. (c) If alive, give age years

8. AGE:

Years
64Months
7Days
4

If less than one day

hrs. min.

9. Birthplace

Crisfield, Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

X X X X X home

Steven Byrd

FATHER

12. Name

Md.

13. Birthplace

Mary Ann

MOTHER

14. Maiden name

Md.

15. Birthplace

Susie Byrd

16. Informant

Crisfield, Md.

Address

Burial

Date thereof
(month) (day) (year)
1/27/45

17. (Burial, cremation, or removal. Which?)

Cemetery or crematory

Crisfield

Location

Crisfield, Md.

18. Funeral director

HOWARD H. HUBBARD

Address

506 Main St., Crisfield,

19. (Date rec'd by registrar)

18.

65 Gallison, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Somerset

City or town Crisfield

(If outside city or town limits, write RURAL and give nearest town)

Street No. Ritchie Blvd.

(If rural, give LOCATION)

2.(a) If veteran, name war none

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24, 1945, a. f. d. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 24, 1945, to January 24, 1945.

and that I last saw her alive on January 23, 1945.

Immediate cause of death

Febrile惊厥

DURATION

6 days

Due to

Due to

Other conditions Chroesic myocarditis

due to myocardial infarction - 6 yrs.

(Include pregnancy within 8 months of death)

Pulmonary embolism & infarction 6 yrs.

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. M. Parker M.D.

M. D. or other

Address Crisfield, Md. Date signed Jan. 27, 1945

